Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DENISE CLAIRE WEINBERG
ST MARY'S BEHAVIORAL PAIN MNGT
3033 FANNIN ST
HOUSTON TX 77004-3258

Respondent Name
ZURICH AMERICAN INSURANCE CO

Carrier's Austin Representative Box
Number 19

MFDR Tracking Number
M4-13-1013-01

MFDR Date Received
December 21, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are requesting your assistance in [sic] from your office in processing medical bills related to the …services rendered on 1/10/12, 1/11/12, 1/13/12, 1/17/12, 1/24/12 and 1/26/12. Payment was denied for the following reason: (W12) Based on Extent of injury. After a reconsideration was sent. We received and [sic] EOB detailing allowance of $800.00 per date of service, but to this date no payment has been received…"

Amount in Dispute: $7200.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not respond.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 10, 11, 13, 17, 24, and 26, 2012	97799-CP x 8hr/day	$7200.00	$4800.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register 3833*, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanations of benefits
   - W12 – extent of injury, not finally adjudicated

- W1 - the reimbursement for this procedure has been calculated according to the guidelines for a program that is not CARF accredited."

Issues

1. Is the disputed service eligible for medical fee dispute resolution according to 28 Texas Administrative Code §133.305 and §133.307?
2. Did the respondent maintain the extent of injury denial?
3. Is the requestor entitled to reimbursement?

Findings

1. A benefit contested case hearing was held to determine the extent of the compensable injury. Per the Decision and Order issued on June 24, 2010, the hearing officer determined the compensable injury extends to include internal derangement of the left knee.

2. The requestor submitted a request for reconsideration and the insurance carrier issued an Explanation of Bill Review with explanation code of W1. The extent of injury denial was not maintained.

3. On February 19, 2013, the requestor was contacted to inquire if payment had been received. The requestor stated that no payment had been received. Further review of the requestor's submitted documentation finds original checks issued in the amount of $0.00 for each of the disputed dates of service. The requestor is entitled to reimbursement.

   28 Texas Administrative Code §134.204(h)(1)(B) states in part that if a program is not CARF accredited, the hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR. The MAR for a chronic pain management program (97799-CP) is $125.00 an hour per 28 Texas Administrative Code §134.204(h)(5)(B). Reimbursement is calculated as follows:

   - 97799-CP: $100.00/hr x 8 hrs/day = $800.00 x 6 days = $4800.00

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $4800.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $4800.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

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Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March , 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.